Billing Update – Claim Submission Timeline
October 14, 2008

Issue: Providers communicated that 90 days for submission of claims to the Division of Health Care Finance and Policy ("Division") presented an issue given the time and resources required to program and test for the transition from the UB to 837-I claims format. Effective January 1, 2008, all hospitals were required to submit data to the Division using the 837-I format. The Division has had numerous communications with hospitals to advise them of this change and to partner on the transition.

Solution: The Division approved a temporary 30-day "grace" period, which would be applied to the claims submission timeline. This grace period afforded providers an additional 30 days to submit their claims data to the Division.

Update: At this time, 81 percent of all providers have passed the testing threshold required for transition from the UB to the 837-I claim format. The Division will be terminating the 30-day grace period effective November 1, 2008. Claims submitted after November 1, 2008 must be received by the Division within 90 days from the date of service or will be denied for exceeding billing deadlines.

Please note that approval of the 30-day grace period only applied to the submission of UB claims. This additional period of time was approved given the Division's recognition of the additional time and effort providers would undertake in their transition to the 837 claims format.